INSTRUCTIONS for CLASSIFIED SERVICE WORKER INJURED on the JOB

An employee of the Police or Fire Department who is subject to Chapter 143 of the Texas Local Government Code.

Employee Name: _____

SS#_____ Employee #_____ Department _____ Job Title_____

Current Home Address_____
(Street address only; no P. O. Box)

City _____ Zip Code _____ Phone No._____

Is place of recovery the same? Yes ____ No ____ If different, list street address and phone number below.

Street Address_____

City _____ Zip Code _____ Phone No. _____

Please place your initials beside each paragraph, in the space provided, as you read each paragraph.

____ I understand that I must immediately report any change in address, phone number, or place of recovery to my supervisor.

DOCTOR YOU ARE SEEING/WILL SEE FOR THIS INJURY:

Name_____

Address_____

Phone Number _____

Hospital/Emergency Room_____

SALARY CONTINUATION

To be eligible for salary continuation benefits, an employee must complete his/her probationary period and must agree to reimburse the City for any overpayment made to the employee.

____ I understand that I am free to choose any doctor to provide the care necessary to treat my injury.

____ I understand that while I am on injury leave, salary continuation will be paid up to an initial one (1) year with the approval of my department head and if supported by medical documentation from my treating doctor. If I need to extend injury leave with salary continuation beyond the initial one (1) year up to a maximum of two (2) years, I must request the extension of leave and salary continuation in writing and provide supporting medical verification from my treating doctor.

TELEPHONE CONTACT

____ I understand that I am personally required to telephone and to report my health condition by contacting one of the following persons before or within the first two (2) hours of my shift every day that I would regularly be scheduled to work while on injury leave.

Primary Contact Person: _____ Phone No. _____

Alternate Contact Person: _____ Phone No. _____

_____ I understand that I must personally continue to telephone the contact person(s) until I contact one of these individuals. No other person may call for me, and no other contact person is acceptable. It is my responsibility to find an available telephone. Only a written doctor's statement explaining why I am medically unable to use a telephone will relieve me of this responsibility.

PHYSICIAN'S STATEMENT (CS Form 227) & MEDICAL APPOINTMENTS

____ If I lose time from work due to an on-the-job injury, I must see a doctor within twenty-four (24) hours of the injury or as soon thereafter as I become aware that an injury has occurred. I understand that I am responsible for having the doctor complete the Physician's Statement (CS Form 227) regarding my treatment and sending it to the Case Management Section of the Human Resources Department. I may also return the completed form in person to the Case Management Section of the Human Resources Department. My department will provide forms and envelopes to me. Additional forms and envelopes are available upon my request.

____ Every ten (10) to fourteen (14) calendar days or as often as seen by the treating physician but no less frequently than every thirty (30) calendar days while unable to return to work full duty I am responsible for having my doctor complete another Physician's Statement (CS Form 227). I may bring or send it to the Case Management Section of the Human Resources Department. The doctor must sign and date the Physician's Statement, and it must have a legible typed or printed name of the doctor near the signature and include the address and phone number.

____ If I am unable to keep a scheduled medical examination, I must call the Case Management Section of the Human Resources Department and explain why the scheduled examination was not kept. I must advise the Case Management Section of the Human Resources Department as to the date of the next examination.

RETURN TO WORK

____ In order to return to duty after injury leave, I must submit a Physician's Statement (CS Form 227) signed by my treating doctor stating that I may return to full or restricted duty. I am expected to return to duty on the date my treating doctor indicates I may return to work whether it be full or restricted duty so long as there are duties for me to perform that I am able to do. Prior to that return-to-work date, I will inform the contact person(s) and the Designated Departmental Representative and get instructions on where to report to work.

____ If I am released by my treating doctor to less than full duty, I may not be able to resume my regular position if I am not able to perform my full duties. In such a circumstance, a temporary transitional duty assignment may be offered to me. I understand that I must accept the offer of employment (to transitional duty assignment) unless I provide, within two (2) calendar days, a written statement from my treating doctor that the transitional duty assignment is not within the restrictions prescribed by the doctor.

OTHER INFORMATION

____ While on injury leave, I may be required to attend safety classes, work-hardening programs, exercise classes, job rehabilitation programs, or other job related classes given by the City, the Safety Office of the Human Resources Department, or any other source authorized by the City. Upon reasonable notification, I must attend such classes unless a doctor's statement expressly explains a specific physical inability that would prevent attendance at such classes or meetings.

____ I understand that while on injury leave, I am obligated as part of my job responsibilities to follow these procedures and am expected to:

- remain at home or at the place of recovery that I reported to my department except for necessary trips to a medical facility, to my department for business reasons, or to the offices of the Third Party Administrator;
- follow all doctor's instructions and do all within my power to recover from the injury;
- cooperate with the City in following the reporting and other requirements of these procedures;
- provide information requested by the department, Case Management, or any doctor selected by the City; and
- promptly and fully carry out other reasonable requests made by the City/TPA.

____ I shall do all within my power to get back to work as soon as practicable. I will not do anything that could aggravate or reinjure myself. Periodic telephone calls and/or visits to my home address or place of recovery shall be made by departmental representatives in order to ensure compliance with these procedures and guidelines.

____ I cannot hold other employment or outside economic activity such as working at home or at a business, including previously approved outside employment, while on injury leave, awaiting approval of injury leave, or on transitional duty.

____ Unless authorized by my treating doctor and the City, I cannot attend classes at any educational center/institution during my regular or off-duty hours.

____ I cannot take trips or otherwise use injury leave for recreational purposes.

____ If I am not medically able to return to my full duty after two (2) years of injury leave with salary continuation, I may request additional leave by means of a Leave Authorization Request (HR Form 206) which may be granted only at the discretion of my department head. Any additional leave will only be paid at the discretion of the department head and in accordance with City ordinances.

____ I am aware that should I not qualify for or receive salary continuation for any reason, I will be compensated through my available accrued leave and acknowledge that said accrued leave will not be returned to my balances.

____ I fully understand that should I go into a full docked status (no City paycheck), I must go to my payroll office for the appropriate form necessary to make separate arrangements with the Human Resources Department Benefits Section to pay for my share of any medical, dental, or life insurance I wish to continue while I am off work due to my injury. I acknowledge and fully understand that if I do not make the separate payments to keep these insurance policies in effect, they may lapse for nonpayment. Should I return to work from my injury and wish to reinstate the above insurance coverage, I will have to fulfill any requirements for reinstatement. Reinstatement may include preexisting condition exclusion.

____ I have been informed that if my injury is a serious health condition, I may request and take Family and Medical Leave if I meet the eligibility requirements and qualify based upon proper medical certification.

____ If, due to administrative error, I receive a weekly benefit check after having returned to work, I will return the check or the amount provided in the check immediately to the Third Party Administrator.

____ I am aware and fully acknowledge that failure to follow these procedures or violations of other City or departmental rules, regulations, or policies may result in a loss of benefits and/or disciplinary action up and including indefinite suspension.

____ **I agree that any overpayments paid in any form as well as any other City funds paid to me that should not have been paid to me may be deducted from my future earnings so long as such deductions do not reduce my earnings below minimum wage in any pay period in which such deductions are made.**

Date _____ _____

Employee Signature

I acknowledge that these procedures were reviewed with the employee and explained, as required, this ____ day of

_____, 19____.

_____

Supervisor/DDR